STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G193	A. BUILDING _____ B. WING _____	R 06/10/2010

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{W 000}	INITIAL COMMENTS A follow-up survey was conducted on 6/9/10 - 6/10/10, to verify that the facility had come into compliance with deficiencies identified in the licensure survey of 5/3/10. It should be noted that the current governing body was appointed by a court to manage this facility "in receivership," effective 5/14/10. The new management submitted a Plan of Correction dated 6/7/10. The follow-up visit revealed that there had been some progress made in the three weeks since the court action. However, through observation, interviews with staff and residents and review of records, the determination was made that the facility remained not in compliance with the Conditions of Participation of Governing Body, Client Protections and Health Care Services, as evidenced in the report that follows.	{W 000}	Received 7/12/10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
{W 102}	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility. [See W104] The results of these systemic practices revealed that the facility's governing body failed to adequately govern the facility in a manner to ensure client protection [See W122]; and health care services[See W318].	{W 102}	See W104 See W122 See W318	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the governing body failed to maintain general operating direction over the facility as evidenced by the deficiencies cited throughout this report and the following: The findings include: 1. The governing body failed to ensure implementation of the incident management system and reporting policies. [See W149, W153 and W189.2] 2. The governing body failed to ensure the provision of preventive health services and nursing services in accordance with clients' needs. [See W322 and W331] 3. The governing body failed to ensure that staff were trained on safe water temperatures (not to exceed 110 degrees Fahrenheit). [See W189.3 and W426]	{W 104}	1. The administration at MarJul Homes recognizes the necessity of an incident management system and reporting procedures. All staff have been trained on the implementation of the incident management system and reporting policies. (see attached training schedule) (see attached sign in sheet) 2. The administration at MarJul Homes recognizes the necessity for nursing services and preventative health services. After an assessment of current nursing services, the following have been instituted to ensure quality preventative health services/ nursing services. -A new RN consultant -Review of all individuals medical records -Assess of all indivudals health status Implementation of Health Maintenance Care Plans (HCMP), with staff training 3. All staff have been trained on safe water temperature practices. (see attached staff memo and training schedule)	7/15/10 and 6/25/10 7/15/10 and 6/25/10 7/9/10
{W 122}	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement policies	{W 122}	All staff will receive training on Human Rights: Abuse and Neglect Training by July 21st. All staff has been trained on the implementation of the incident management system and reporting policies. (see attached training schedule) (see attached sign in sheet)	7/21/10

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{W 122}	Continued From page 2 and procedures that ensured clients' health and safety [See W149]; and, failed to ensure that an incident of physical abuse (peer-on-peer) was reported [See W153]. The effects of these systemic practices resulted in the failure of the facility to protect its clients and ensure their health and safety.	{W 122}		7/15/10 and 6/25/10
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies to ensure the health and safety of one of the four clients in the sample. (Client #3) The findings include: 1. The facility failed to ensure that all allegations of abuse were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, in accordance with federal regulations and state law, as follows: [Cross-refer to W153] On 6/9/10, review of Client #4's behavior data revealed that direct support staff documented a behavioral incident on 5/25/10, in which Client #4 hit Client #3 in the head. They did not, however, complete a corresponding incident report. There was no evidence that the facility's administrator and HRLA were notified of the 5/25/10 incident. On	{W 149}	1. All staff will receive training on Human Rights: Abuse and Neglect Training by July 21st. All staff has been trained on the implementation of the incident management system and reporting policies. (see attached training schedule) 2. The administration at MarJul Homes recognizes the importance of safe medication practices and medical follow up. A policy regarding the safe use of PRN medications has been developed. All nursing staff have been trained on this policy. In addition, all staff have received training on the protocol for Bowel Movement documentation and monitoring. (see attached sign in sheets)	7/21/10 7/15/10 and 6/25/10

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{W 149}	Continued From page 3 6/9/10, at approximately 3:15 p.m., the qualified mental retardation professional (QMRP) stated that the facility had not provided in-service training for staff on their incident management system since the provider agency was appointed by a court on 5/14/10 to manage the facility. At 4:05 p.m., interview with two direct support staff confirmed that there had been no training on incident management or abuse/neglect. At 4:46 p.m., review of the facility's Incident Management System (IMS) Policy and Procedures (not dated) revealed that abuse of an individual by another individual was prohibited and "physical abuse" was defined to include "intentionally or willfully grabbing ...slapping, hitting ...punching, or otherwise wrongfully handling an individual." 2. Based on interview, and record review, the facility failed to develop and implement policies that address the use of PRN medications, and monitoring for their effectivess, as follows: [Cross-refer to W322] The monitoring survey conducted from 4/29/10 to 5/3/10 revealed Client #3 had a history of bowel obstruction and multiple emergency room (ER) visits due to constipation. During the monitoring survey, on 4/30/10, Client #3 was taken to an ER after complaining of abdominal pain. Review of the client's bowel movement (BM) records on 4/30/10 revealed that his most recent BM had been documented on 4/24/10, 6 days earlier. His physician's orders included two different medications (constulose or milk of magnesia MOM) to be administered PRN for constipation. The orders, however, did not specify when to administer one or the other medication. There were no other instructions or protocols available to further clarify. On 5/3/10, at 7:40 p.m., the Supervisory Registered Nurse (RN)	{W 149}	6. The administration at MarJul Homes recognizes the importance of safe medication practices and medical follow up. A policy regarding the safe use of PRN medications has been developed. All nursing staff have been trained on this policy. In addition, all staff have received training on the protocol for Bowel Movement documentation and monitoring. (see attached sign in sheets)	7/15/10 and 6/25/10

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{W 149}	Continued From page 4 confirmed that Client #3's record failed to include instructions or a protocol on when he was to receive the PRN medications. This deficient practice was cited in the federal deficiency report dated 5/3/10. The follow-up survey initiated on 6/9/10, revealed that Client #3 was taken again to an ER on 5/27/10 and was diagnosed with constipation and fecal impaction. Following his return from the ER, there was a 5-day gap between stools indicated in his BM chart. He received MOM on the 5th day. As of 6/10/10, the facility still had not established a written protocol or obtained orders that clarified when to administer Client #3's PRN medication for constipation This is a repeat deficiency. --- Previously, the federal deficiency report dated 5/3/10, included the following: 1. The facility failed to ensure the Department of Health (DOH) was notified timely of significant incidents (allegations of abuse and one injury of unknown origin) in accordance with federal regulations and state law. [Cross-refer to W153] Review of the facility's incident and investigation reports on 4/30/10 and 5/3/10, revealed evidence of three incidents of abuse, and one injury of unknown origin that were documented to have occurred between 9/09 and 2/10. Continued review of the facility's incident reports failed to show evidence that the Department of Health (DOH) was informed the aforementioned incidents timely.	{W 149}		

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{W 149}	Continued From page 5 Interviews with the resident manager (RM) and qualified mental retardation professional (QMRP) were conducted on 5/3/10, at 4:00 p.m., and 7:20 p.m., respectively. They both indicated that staff who witnessed, discovered or were informed of the aforementioned incidents should have immediately documented the incidents on an incident report form, before the end of the shift. The RN and the QMRP stated that DOH should have been notified of all allegations of abuse and injuries of unknown origin immediately, followed by written notification within 24 hours. Review of the facility's incident management policy (IMP) on 5/3/10, at approximately 6:00 p.m., revealed that incidents were categorized into both reportable and serious reportable incidents. Allegations of abuse, neglect and injuries of unknown source were identified as serious reportable incidents. According to the policy, staff were required to "immediately call" the case manager, DOH, and the client's parent or guardian for all serious reportable incidents. Incident report forms were to be completed on "all serious reportable incidents" and the incident report was to be forwarded to the DOH within 24 hours. Review of the facility's incident report, however, revealed that the facility had not consistently notified the State agency of incidents, as required. [Paragraphs 2., 3., 4., and 5. of the 5/3/10 deficiency report were deleted for brevity in 6/10/10 deficiency report] 6. [Cross-Refer to W322] The facility failed to ensure the effective implementation of its policy on "Medication Management."	{W 149}		

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{W 149}	Continued From page 6 The review of Client #3's record revealed that the facility's medical services failed to monitor the effectiveness of a prescribed medication. The review of the facility's Medication Management policy, section IV(a), Medication Monitoring (dated 1/08) on 5/3/10, at 11:07 a.m. revealed, "All medications shall be monitored by a physician." Interview with the nursing staff and the record review on 4/30/10 and 5/3/10 revealed that the effectiveness of medications prescribed for constipation, (Constulose10 gm/15 ml syrup, 30 ml by mouth daily), as needed and Milk of Magnesia, 1 ounce by mouth as needed in the evening) had not been closely monitored by the physician.	{W 149}		
{W 153}	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and review of client records, including incident reports and investigations, the facility failed to ensure that all allegations of abuse were reported immediately to the administrator and/or the Department of Health, Health Regulation and Licensing Administration (HRLA) timely, for one of the four clients in the sample. (Client #3) The finding includes:	{W 153}	See W 104 - Incident management system and W 149.1	

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{W 153}	Continued From page 7 On 6/9/10, at 11:58 a.m., review of Client #4's behavior Antecedent Behavior Consequence (ABC) data sheets revealed that on 5/25/10, at 4:30 p.m., a direct support staff person wrote: A - "She was sitting down talk about food and going to the store. " B - "She hit <Client #3> in the head and lip." C - "Tell her to stop and happy face and smiley face and she stop <sic>. She said she's sorry to <Client #3>." Review of Client #4's Daily Progress Notes revealed that the same staff had documented "yes" the client had "displayed behaviors" and "no" there were no incidents. There was no corresponding incident report in the facility. A pre-survey review of incident reports had not revealed any incidents of physical abuse. On 6/9/10, the qualified mental retardation professional (QMRP) arrived in the facility at approximately 12:30 p.m. She stated there had been no reports of anyone being hit in the head or face since she was assigned as QMRP on 5/14/10. If staff were to witness a client hit another client, "that would be abuse." She further stated that the facility's policies require staff to notify their supervisor and the QMRP would instruct them to complete an incident report. On 6/9/10, beginning at 4:46 p.m., review of the facility's Incident Management System (IMS) Policy and Procedures (not dated) confirmed what the QMRP had stated earlier. The IMS was "designed to protect individuals from harm ... ensure timely and accurate notification of appropriate staff, families and agency officials ... ensure completion of investigation and documentation of incidents ... corrective action to prevent the recurrence of similar incidents ... staff	{W 153}		

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{W 153}	Continued From page 8 training in the prevention, detection, reporting and investigation of incidents." Abuse of an individual by another individual was prohibited and "physical abuse" was defined to include "intentionally or willfully grabbing ...slapping, hitting ...punching, or otherwise wrongfully handling an individual." On 6/9/10, beginning at 2:16 p.m., review of the Daily Log Book (in which staff documented their activities throughout their shift), revealed the following entry dated 5/25/10, 4:30 p.m.: "<Client #4> hit <Client #3>. She went into her behavior then <Client #3> went into he's <sic> behavior but <Client #4> are all right, and she busted <Client #3> mouth open, yes he's ok." On 6/9/10, at 3:55 p.m., the direct support staff whose initials were on the Daily Log Book entry replied "no" when asked if any client had been hit by a peer. The same staff was interviewed again the next day at 3:47 p.m., at which time he confirmed Client #4 had hit Client #3 in the head. He further described that after he was hit in the head, Client #3 started biting his own hand, fell to the floor crying and continued acting out. There was no evidence that the facility's administrator and HRLA were notified of the 5/25/10 incident. The staff had not completed an incident report, in accordance with their policy. It should be noted that the current governing body was appointed by a court to manage this facility, effective 5/14/10. On 6/9/10, at approximately 1:40 p.m., interview with the QMRP revealed that six of their thirteen direct support staff had been employed by the previous provider agency. At approximately 3:15 p.m., she acknowledged that they had not provided in-service training for staff on their incident management system since	{W 153}		

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{W 153}	Continued From page 9 5/14/10. At 4:05 p.m., interview with two direct support staff confirmed that there had been no training on incident management or abuse/neglect. This is a repeat deficiency. Previously, the federal deficiency report dated 5/3/10, included the following: 1. An incident report (injury of unknown origin) dated 2/8/10, revealed that Client #1 complained to staff that his neck was bothering him ... There was no documented evidence, however, that the administrator was immediately notified of Client #1's injury of unknown origin, as required. 2. An incident report dated 11/8/09, and corresponding investigation report dated 11/10/09, revealed an allegation of sexual abuse. Client #1 reported to staff that another staff had put his hands down his pants ... Interview with the previous Incident Management Coordinator ...acknowledged that the administrator was not notified immediately of the allegation of sexual abuse until two days later. 3. An incident report dated 9/26/09, and corresponding investigation report, revealed an allegation of verbal/physical abuse. Client #2 came into the QMRP's office and stated that a "counselor" told him to shut up "and pushed him off the van ...Interview with the QMRP on 4/30/10, at approximately 7:30 p.m., acknowledged that the administrator was not notified immediately of the allegation of abuse.	{W 153}		

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{W 153}	Continued From page 10 4. An incident report dated 10/2/09, and corresponding investigation report dated 10/13/09, revealed an allegation of verbal abuse. While in court, Client #2 kept raising his hand to speak. The judge allowed him to speak, and the client stated "staff was hollering at him." Further review of the incident report revealed that the administrator was not informed of this allegation.	{W 153}		
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4 and #5) The findings include: 1. [Cross-refer to W153] The QMRP failed to ensure that staff received training on the facility's incident management policies, and abuse, neglect and resident rights. 2. [Cross-refer to W189.1 and W252] The QMRP failed to ensure that direct support staff received training on consistent and accurate documentation of behavioral incidents. 3. [Cross-refer to W426] The QMRP failed to ensure that staff were trained on safe water temperatures (not to exceed 110 degrees	{W 159}	1. See W 104 Incident management system and reporting policies. 2. New programs and books have been developed for all individuals. Staff will be trained on the new programs by Friday, July 9th. 3. See W 104 Safe Water Temperature and W149 4. Nutrition training was conducted by a nutritionist and held on June 14th. See attached sign in sheet and curriculum. 5. Nutritional assessments were completed and new menus were developed and placed in the home. 6. Updated nutritional assessments have been completed. (see attached assessments)	7/9/10 7/9/10 6/14/10

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{W 159}	Continued From page 11 Fahrenheit). 4. [Cross-refer to W460.1] The QMRP failed to coordinate services to ensure menus were modified as necessary to provide Client #3 high fiber foods, as prescribed. 5. The QMRP failed to ensure Client #3's nutritional assessment was provided timely for the implementation of recommended interventions, as evidenced below: On 6/9/10 at approximately 5:10 p.m., interview with the DCS revealed, that Client #3's food is chopped to bite size because he tolerates it best in that texture. The staff further indicated, "We have not received any specific instruction concerning his diet, so we are preparing the food the way we did before the management changed. We are still giving prune juice in the morning and evening and offer him a lot of water." It should be noted that on 5/19/10, the PCP prescribed the client a "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily." Interview with the QMRP on 6/9/10, at 12:30 p.m., revealed that she would telephone the nutritionist to obtain the complete evaluation, and that it should be available on 6/10/10. Interview with the QMRP on 6/10/10, at 4:00 p.m. revealed, that Client #3's complete nutrition evaluation had not been received from the nutritionist yet. Record review on 6/9/10, at 1:25 p.m., revealed a nutrition note dated 6/2/10, which stated Client #3 had been visited by the nutritionist on 6/2/10. The nutritionist noted "At this time, his nutritional status appears stable. The current diet of mechanical soft texture is synonymous to a	{W 159}		

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{W 159}	Continued From page 12 ground diet diet on the menus" used by the provider. [Client] should receive a ground texture. A full nutritional assessment will follow. " At the time of the survey, the outcome of the nutritional assessment had not been communicated to the LPNC, the QMRP, or the PCP to ensure that recommendations were timely implemented, in accordance with the client's needs. 6. [Cross-refer to W460.2] There was no evidence that the QMRP had followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Client #3. Citation W460 in the federal deficiency report dated 5/3/10, included the following: "According to the <nutritionist's 4/29/10> assessment, the client was 'having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening.' At the time of the survey, however, the SLP screening had not been scheduled." On 6/9/10, at approximately 3:15 p.m., interview with the QMRP revealed that she had not contacted the speech-language therapist (SLP) since she began serving as the QMRP on 5/14/10. She indicated that the facility's executive director planned to call the SLP to schedule appointments. She further indicated that the SLP "has to come. We're going to get everyone an assessment...all of them are outdated." On 6/9/10, at approximately 5:10 p.m., a direct	{W 159}		

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{W 159}	Continued From page 13 support staff was observed in the kitchen, chopping food with a knife. When asked, she stated that she and other staff always chopped Client #3's foods to help his swallowing. However, review of the client's physician's orders failed to show evidence that the recently-assigned PCP had been made aware of the previous recommendations for altered food texture and an SLP screening. On 5/19/10, the PCP wrote the following dietary orders: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily." [It should be noted that on 6/2/10, a new nutritionist wrote "<Client #3> was assessed for a complete nutrition evaluation...The current diet of mechanical soft texture is synonymous to a ground diet ... <Client #3> should receive a ground texture."] This is a repeat deficiency. --- Previously, the federal deficiency report dated 5/3/10, included the following: 1. The facility's QMRP failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective for Clients #3 and #4. [See W252] 2. The facility's QMRP failed to coordinate services to ensure menus were modified as necessary to provide the prescribed diet of Client #3. [See W460]	{W 159}		
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

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W 189	Continued From page 14 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained on documenting targeted maladaptive behaviors in the clients' behavior data, failed to provide incident management training to ensure that staff recognized potential abuse, and failed to ensure that all staff was trained on maintaining safe water temperatures, for 13 of the 13 direct support staff in the facility. The findings include: 1. [Cross-refer to W252] On 6/9/10, at approximately 8:15 a.m., Client #3 was observed to remove all of his clothing while standing in the living room. Review of his records the next day, at 8:55 a.m., revealed that the staff who were on duty at the time failed to document the incident in on his behavior data sheets. Another behavioral incident was indicated in a staff log entry on 6/6/10; however, it too had not been documented in the program book, in accordance with the client's behavior support plan (BSP), dated 4/19/10. On 6/9/10, at approximately 3:15 p.m., interview with the qualified mental retardation professional (QMRP) revealed that the facility had not provided in-service training since new management was appointed by a court on 5/14/10. This was corroborated a short time later (4:05 p.m.) by two direct support staff who were interviewed.	W 189	See attached Training Calendar	

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W 189	Continued From page 15 2. [Cross-refer to W153] The facility failed to ensure staff was trained on recognizing abuse and neglect, resident rights and the facility's incident management policies. On 6/9/10, at 11:58 a.m., review of Client #4's behavior data and Daily Progress Notes revealed that staff had documented an incident 5/25/10 when Client #4 hit Client #3 on the head. On 6/9/10, at approximately 12:30 p.m., the qualified mental retardation professional (QMRP) stated there had been no reports of anyone being hit in the head or face since she was assigned as QMRP on 5/14/10. If staff were to witness a client hit another client, "that would be abuse." On 6/9/10, at approximately 3:15 p.m., the QMRP acknowledged that they had not provided in-service training for staff on their incident management system since 5/14/10. At 4:05 p.m., interview with two direct support staff confirmed that there had been no training on incident management or abuse/neglect. On 6/10/10, at 2:50 p.m., the QMRP indicated that staff training had not yet been scheduled for abuse and neglect, resident rights and incident management policies. She added, however, that "it will be" scheduled soon. 3. [Cross-refer to W426] The morning shift had documented hot water temperatures exceeding 110 degrees on three different dates (6/1/10, 6/5/10 and 6/9/10) and failed to notify management, as per written instructions. On 6/9/10, at approximately 3:15 p.m., the QMRP acknowledged that they had not provided in-service training for staff on maintaining safe water temperatures. At 4:05 p.m., interview with	W 189		

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W 189	Continued From page 16 two direct support staff confirmed that there had been no training provided. On 6/10/10, at 2:50 p.m., the QMRP indicated that staff training on nutrition (6/14/10) was the only topic scheduled thus far.	W 189		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all staff were effectively trained to address the implement the prescribed diet, for one of the four sampled clients. (Client #3) The finding includes: Cross-refer to W460. On 6/9/10, at 4:16 p.m., Client #3 was offered sugar wafers for afternoon snack. The nutritionist, however, had recommended that he receive hi-fiber snack items, in part to address recurrent bouts of constipation and fecal impactions. Interview with the direct support staff on 6/9/10, at approximately 5:10 p.m., revealed that she was previously unaware of the recommended high fiber snacks. She stated that she had not received any training on diet plans and snack choices. She further indicated that there was no list of high fiber snacks available for staff reference. On 6/9/10, beginning at 3:11 p.m., the qualified mental retardation professional (QMRP) stated that the facility had not provided staff in-service training since the new management	W 192	Nutrition training was conducted by a nutritionist and held on June 14th. See attached sign in sheet and curriculum. Nutritional assessments were completed and new menus were developed and placed in the home.	6/14/10

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W 192	Continued From page 17 team was appointed on 5/14/10. This was also verified through review of training records on 6/10/10, at approximately 1:00 p.m. [Note: On 6/10/10, at 2:50 p.m., the QMRP pointed to announcements posted in the facility, for mandatory staff training by the nutritionist. It was scheduled for 6/14/10.]	W 192		
{W 252}	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objectives, for one of the four clients in the sample. (Client #3) The findings include: 1. Observation on 6/9/2010 at 8:06 a.m., revealed Client #3 removed his shirt, threw it across the room, dropped his pants and stood naked next to the sofa. The direct support staff immediately intervened, instructing him to put his clothes back on, while other staff quickly escorted the other clients out of view. Client #3's behavior support plan (BSP) dated 4/19/10, was reviewed the next morning (6/10/10), beginning at 8:38 a.m. "Disrobing" or "removing clothes not in the bathroom/bedroom" was one of several challenging maladaptive	{W 252}	1. Training with all staff is scheduled to occur on regarding individual BSP' and documentation of behaviors.	7/29/10

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{W 252}	Continued From page 18 behaviors identified in the BSP. According to the Frequency of Targeted Behavior Form and the ABC Data Collection Sheet, staff should document each episode of a targeted behavior that was observed. Review of the aforementioned forms on 6/10/10 at approximately 8:45 a.m., revealed that staff had not documented the 8:15 a.m. disrobing episode on the ABC Data Collection Sheet. [Note: Staff had documented another episode of disrobing ealier that morning, at "7:30 a.m. ...just before breakfast."] 2. On 6/9/10, at approximately 3:30 p.m., review of the Daily Log Book (in which staff documented their activities throughout their shift), revealed the following entry dated 6/6/10, at 6:00 a.m. "<Client #3 stripped totally and wet on the sofa; sofa cleaned and left to dry out." Review of the ABC Data Collection Sheet on 6/10/10, at approximately 8:45 a.m., revealed that there was no documentation of the observed targeted behavior. This is a repeat deficiency. --- Previously, the federal deficiency report dated 5/3/10, included the following: The facility failed to ensure that data was consistently maintained on the training objectives designed to improve behavior of Clients #3 and #4, as evidenced below: a. Observation of Client #4 on 4/29/10, at approximately 6:19 p.m., revealed she began talking to herself, as she repeatedly hit herself on	{W 252}		

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{W 252}	Continued From page 19 the left side of her head ... Review of Client #4's behavior support plan (BSP) dated 8/17/09, on 4/30/10 at 9:24 a.m., revealed the client exhibited self-injurious behaviors (SIB), which included punching herself on face or head. According to Frequency of Targeted Behavior Form, the face slapping/punching behavior should be documented. The ABC Data Collection Sheet also required that antecedents, behaviors, interventions, and responses to the intervention be documented each time staff observe the client exhibit a targeted behavior. Review of the aforementioned forms on 4/30/10 at 9:35 a.m., revealed that the face slapping observed by the surveyor on 4/29/10 during the medication administration had not been documented. b. Observation of Client #3 during the medication administration on 4/29/10, at 7:26 p.m. revealed he slapped himself repeatedly on the right side of his face... He then got up from the chair, cursing loudly, and began "puffing and blowing" ... There was no documentation on the ABC Data Collection Sheet concerning the observed targeted behavior.	{W 252}		
{W 318}	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interviews, and record verification, the facility failed to ensure timely preventive health services were coordinated [See W322]; the facility's nursing services failed to establish systems to provide health care monitoring and identify services in accordance with clients' needs	{W 318}	The nutritionist trained on prescribed diets on June 14, 2010 with all staff. The QMRP will monitor that the prescribed diet is being provided to the individuals weekly x 4 for one meal, then monthly x 3, then quarterly. (See attached sign-in sheet)	6/14/10

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{W 318}	Continued From page 20 [See W331]; and the facility failed to ensure therapeutic diets were provided as prescribed [See W460]. The effects of these systemic practices resulted in the demonstrated failure of the facility to provide health care services.	{W 318}		
{W 322}	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure timely preventive health services, for two of the four sampled clients. (Clients #3 and #4) The findings include: 1. The monitoring survey conducted from 4/29/10 to 5/3/10 revealed Client #3 had a history of bowel obstruction and multiple emergency room (ER) visits due to constipation. During the monitoring survey, on 4/30/10, Client #3 was taken to an ER after complaining of abdominal pain. Review of the client's bowel movement (BM) records on 4/30/10 revealed that his most recent BM had been documented on 4/24/10, 6 days earlier. His physician's orders included two different medications (constulose or milk of magnesia MOM) to be administered PRN for constipation. The orders, however, did not specify when to administer one or the other medication. There were no other instructions or protocol available to further clarify. On 5/3/10, at 7:40 p.m., the Supervisory Registered Nurse (RN)	{W 322}	1. The administration at MarJul Homes recognizes the importance of safe medication practices and medical follow up. A policy regarding the safe use of PRN medications has been developed. All nursing staff have been trained on this policy. In addition, all staff have received training on the protocol for Bowel Movement documentation and monitoring. (see attached sign in sheet) 2. We recognize the importance of timely follow up on laboratory results and communications with the physicians. All nurses have been trained on laboratory/ diagnostic testing protocol.	7/15/10 and 6/25/10 7/15/10

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{W 322}	Continued From page 21 confirmed that Client #3's record failed to include instructions or a protocol on when he was to receive the PRN medications. This deficient practice was cited in the federal deficiency report dated 5/3/10. The follow-up survey initiated on 6/9/10, revealed that the facility still had not established a written protocol or obtained orders that clarified when to administer Client #3's PRN medication for constipation, as follows: On 6/9/10, beginning at approximately 8:50 a.m., the licensed practical nurse coordinator (LPNC) described that on 5/27/10, a medication nurse had observed Client # 3 lying on the floor and complaining of stomach pains. The nurse telephoned 911 and the client was transported to the ER for evaluation. The ER discharge summary revealed a primary diagnosis of stomach pain and a secondary diagnosis of constipation - acute abdominal: fecal impaction. At approximately 8:57 a.m., the LPNC stated that although there were no written instructions or orders on administering the PRN lactulose or MOM, she was expected to administer the PRN as a laxative if Client #3 did not have a BM in 3 days. Further review of the hospital discharge summary revealed the following recommendations: provide Client #3 a diet high in fiber, including raw fruits and vegetables and bran to prevent constipation; 10 to 12 cups of water daily; Dulcolax 5mg every evening for 10 days; and, contact your primary care physician (PCP) as soon as possible to schedule a follow-up appointment in 2-3 days. On 6/9/10, at approximately 11:50 a.m., review of	{W 322}		

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{W 322}	Continued From page 22 Client #3's nursing progress note revealed an entry dated 5/27/10, (5:10 p.m.) which documented that the PCP was notified of the outcome of the ER visit and the discharge recommendations. The PCP concurred with the hospital recommendation to begin administering Dulcolax 5 mg tab, 1 tab daily. The 5/28/10 physician's orders continued to include Enulose and Milk of Magnesia as PRN medications. The orders did not, however, specify when to administer either one or the other medication PRN for constipation, nor did the orders address daily water/fluid intake. On 6/9/10, at approximately 2:45 p.m., review of Client #3's bowel movement (BM) records revealed that staff documented a BM on 5/27/10 during the evening shift. The next documented BM was during the evening shift on 6/1/10, 5 days later. Review of the MAR revealed that the LPNC administered MOM at 3:00 p.m. on 6/1/10 and again on 6/2/10. It should be noted that the corresponding nurse progress note from 6/1/10 indicated that the client had been 3 days without a BM, whereas his BM chart showed 5 days. After she administered the MOM on 6/1/10 and 6/2/10, the nurse documented a call to the PCP on 6/3/10, at which time the PCP increased the Dulcolax from 5 mg daily to 10 mg every evening. On 6/10/10, at 3:00 p.m., the client's BM chart showed that his stools remained mostly hard between 6/4/10 - 6/8/10. When the client went to the PCP's office on 6/10/10 for a "post-ER visit," she discontinued the PRN Lactulose order and started him on Lactulose 30 ml every evening. However, as of 6/10/10, Client #3's record failed to include instructions or a protocol on when he	{W 322}		

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{W 322}	Continued From page 23 was to receive "Milk of Magnesia 30 ml by mouth every evening as needed for constipation." 2. The facility's medical team failed to establish and implement a system to ensure timely review of the findings/reports of diagnostic laboratory tests. Cross-refer to W331.2. Clients #3 and #4 had both received lab testing on 5/20/10, as ordered by the PCP. The results were reported to the facility by facsimile on 5/25/10. However, further review of the clients' medical charts followed by interviews with the qualified mental retardation professional and the LPNC (on 6/9/10, at 1:16 p.m. and 6/10/10, at 9:50 a.m., respectively) revealed that to date, the lab report findings had not been shared with or reviewed by the PCP. [Note: Client #4's urinalysis showed abnormal results and Client #3's report indicated elevated serum potassium.]	{W 322}		
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing services were provided in accordance with the needs of two of the four sampled clients. (Clients #3 and #4) The findings include: 1. The facility's nursing services failed to coordinate with the primary care physician (PCP) to establish a protocol on when to administer Client #3 a prescribed as needed (PRN)	{W 331}		

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{W 331}	Continued From page 24 medication to treat constipation, as follows: [Cross-refer to W322] The monitoring survey conducted from 4/29/10 to 5/3/10 revealed Client #3 had a history of bowel obstruction and multiple emergency room (ER) visits due to constipation. His physician's orders included two different medications (constulose or milk of magnesia MOM) to be administered PRN for constipation. The orders, however, did not specify when to administer one or the other medication and there were no written instructions or protocol in his records to further clarify. This deficient practice was cited in the federal deficiency report dated 5/3/10. The follow-up survey on 6/9/10 - 6/10/10 revealed that Client #3 had been taken to a hospital ER on 5/27/10. The ER discharge summary revealed a primary diagnosis of stomach pain and a secondary diagnosis of constipation - acute abdominal: fecal impaction. Further review of the client's chart, and interviews with the licensed practical nurse coordinator (LPNC) revealed that the PCP had made adjustments to the client's medication regimen. However, as of 6/10/10, Client #3's record still failed to include instructions or a protocol on when he was to receive "Milk of Magnesia 30 ml by mouth every evening as needed for constipation." 2. The facility's nursing services failed to ensure the results of laboratory studies were reported timely to the PCP, as evidenced below: a. On 6/9/10, beginning at 10:59 a.m., review of the lab reports in Client #4's records revealed that she had received a urinalysis testing performed on 5/20/10. The lab report showed the date of	{W 331}	1. The administration at MarJul Homes recognizes the importance of safe medication practices and medical follow up. A policy regarding the safe use of PRN medications has been developed. All nursing staff have been trained on this policy. In addition, all staff have received training on the protocol for Bowel Movement documentation and monitoring. (see attached sign in sheet) 2. We recognize the importance of timely follow up on lab results and communications with the physicians. All nurses have been trained on laboratory/ diagnostic testing protocol. 3. MarJul Homes has acquired a new RN who will be providing oversight of the individuals'care. Her start date was June 11, 2010.	7/15/10 and 6/25/10 7/15/10 6/11/10

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{W 331}	Continued From page 25 5/25/10 in the facsimile markings across the top of the page. Review of the test results revealed the following abnormal findings: UA clarity: cloudy (reference clear); UA blood: large (reference negative); UA protein: 30 (reference negative); UA red blood cells: 117H (reference 0-4/hpf); UA squam cells: 19H (reference 0-5/hpf); and, the presence of mucous and amorphous cells was detected. Further review of the lab report failed to show evidence of a review by a nurse or the PCP. On 6/9/10, at 11:13 a.m., review of Client #4's nursing progress notes revealed that the 5/20/10 lab work was reflected "report pending." On 6/9/10, at 1:16 p.m., the qualified mental retardation professional (QMRP) indicated that lab reports were usually received first by the facility. The licensed practical nurse coordinator (LPNC) reviews the report and makes an entry in the client ' s record. The LPNC then places the lab report in the front of the medical chart for review by the PCP. The LPNC was interviewed in the facility the next morning (6/10/10) at 9:50 a.m. She confirmed the procedure as described earlier by the QMRP. She stated that the findings of Client #4's urinalysis had not been shared with the PCP to date. She would call the PCP if there were abnormal test findings. She then acknowledged that the lab report received on 5/25/10 had been filed into Client #4's chart without having received adequate review. b. Similarly, on 6/9/10, at 12:55 p.m., review of Client #3's general chemistry lab reports revealed that on 5/20/10, test results indicated that he had elevated serum potassium levels, at 5.3 mmol/L	{W 331}		

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{W 331}	Continued From page 26 (Reference range: 3.5 -5.1 mmol/L). The lab report showed the date of 5/25/10 in the facsimile markings across the top of the page. Further review of the lab report failed to show evidence of a review by a nurse or the PCP since the time the findings were received by the facility. On 6/10/10, beginning at 9:50 a.m., the LPNC stated that Client #3 and his peers had all received general physical evaluations by the PCP on 5/21/10. She acknowledged that the results of the blood work were not received by the group home until 5/25/10, four days after the physical evaluation. The nurse further acknowledged that the results of the general chemistry (including elevated potassium levels) had not been reported to the PCP. 3. On 6/9/10, at approximately 8:30 a.m., interview with the LPNC indicated that there was a consulting Supervisory RN. The LPNC further indicated the RN had come to the facility twice since they began providing management for this facility on 5/14/10. Review of the clients' charts, however, revealed no evidence of any RN oversight. During the Exit conference on 6/10/10, at approximately 4:15 p.m., the facility's executive director indicated that the consultant RN had failed to perform the duties as agreed and she therefore, had secured the services of another RN, who would begin shortly.	{W 331}		
{W 356}	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.	{W 356}		

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{W 356}	Continued From page 27 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure timely treatment services for the maintenance of dental health of one of three clients in the sample. (Client #3) The finding includes: The monitoring survey conducted from 4/29/10 to 5/3/10 revealed on 10/1/09, the periodontist diagnosed Client #3 with severe gingivitis, heavy plaque and calculus, and generalized caries of teeth #4, #12 and #15. During a dental visit on 2/3/10, and again on 4/7/10, the periodontist recommended that the client's "Generalized caries" needed to "be addressed by general dentist." These findings were previously cited in the federal deficiency report dated 5/3/10. Interview with the licensed practical nurse coordinator (LPNC) on 6/10/10, at 3:35 p.m., revealed Client #3's caries of teeth #4, #12 and #15 had not been addressed, to date. Continued interview with the LPNC, however, revealed a 6/9/10 previously scheduled appointment with the periodontist had been kept; however, no services were rendered. On 6/10/10, at 3:42 p.m., review of the dental consultation report dated 6/9/10 revealed, that Client #3 was denied treatment services because the periodontist did not participate in the Medicaid program. At the time of the 6/10/10 survey, there was no evidence that the Client #3's caries had been filled as recommended by the periodontist on	{W 356}	We recognize the importance of dental care and all dental appointments, both preventative and acute, have been scheduled. We will ensure that the periodontal care is continued regardless of payment method.	

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{W 356} W 426	Continued From page 28 10/1/09. 483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure water temperatures did not to exceed 110 degrees Fahrenheit. The findings include: 1. On 6/9/10, at approximately 2:00 p.m., the hot water temperature measured 118 degrees Farenheit in the bathrooms located on the first floor and the basement. The water temperature in the two bathrooms located on the second floor measured 116 degrees Fahrenheit. Upon notification of the water temperature readings, the CEO/administrator turned down the setting on the hot water heater. At approximately 5:30 p.m., hot water temperatures were retested at all of the previously identified installations. The temperatures ranged from 95 to 100 degrees Fahrenheit. There was no evidence, however, that the facility had consistently ensured that the hot water temperatures did not exceed 110 degrees Fahrenheit. 2. On 6/9/10, at approximately 2:20 p.m., review of the hot water temperature log that was posted in the kitchen revealed the following temperatures	{W 356} W 426	All staff have been trained on safe water temperature practices. (see attached staff memo and training schedule)	6/9/10

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W 426	Continued From page 29 that were recorded by staff: 6/1/10, a.m. shift: 119 degrees 6/5/10, a.m. shift: 115 degrees 6/9/10, a.m. shift: 115 degrees Further interviews with the QMRP and the CEO/administrator revealed that staff had not brought the temperature readings to management's attention. The "Hot Water Temperature Log" sheet had instructions that included "The hot water temperature should be maintained no greater than 110 degrees. The log sheet also instructed staff to notify management of temperatures exceeding 110 degrees.	W 426		
{W 460}	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the therapeutic diet was provided as prescribed for one of three clients in the sample. (Client #3) The finding includes: The monitoring survey conducted from 4/29/10 to 5/3/10 revealed Client #3 had a history of bowel obstruction and multiple emergency room (ER) visits due to constipation. On 6/9/10 at 12:40 p.m., review of an unusual incident dated 5/27/10 revealed at 6:20 a.m., the medication nurse observed Client # 3 lying on the floor and complaining of stomach pains. The nurse telephoned 911 and the client was	{W 460}	1. Nutrition training was done on June 14, 2010. HMCP training was conducted on July 2, 2010 which incorporated his dietary needs for high fiber as well as 10-12 cups of water a day. As mentioned previously, the QMRP will be monitoring meal to ensure that the prescribed diet is being provided.	6/14/10

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{W 460}	Continued From page 30 transported to the emergency room. On 6/9/10 at 5:10 p.m., review of the discharge summary dated 5/27/10, revealed Client #3 was assessed and treated at the ER, then returned to the group home on the same evening. Observation, interview and record review during the follow-up survey conducted on 6/9/10 and 6/10/10, revealed the following concerns: The facility failed to ensure Client #3 was provided a modified (high fiber) diet in accordance with his assessed needs, as evidenced below: On 6/9/10 at 4:16 p.m., Client #3 and his housemates were observed eating sugar wafers as an afternoon snack. Interview with staff revealed that they were sugar-free wafers. On 6/9/10 at 5:12 p.m., the ER discharge summary revealed a primary diagnosis of pain - abdominal, generalized and a secondary diagnosis of constipation - acute abdominal pain: fecal impaction. The ER discharge summary recommended a diet high in fiber, including raw fruits and vegetables and bran to prevent constipation. Additionally, 10 to 12 cups of water were recommended daily Client #3's physician's orders, initially prescribed on the 5/19/10, were as follows: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily." On 6/9/10, at approximately 5:05 p.m., interview with the direct care staff (DCS), qualified mental retardation profession (QMRP), and the licensed practical nurse coordinator (LPNC) revealed the client received the prune juice twice daily. Continued interview, however,	{W 460}		

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{W 460}	Continued From page 31 failed to confirm that the client had consistently received high fiber snacks. Additionally, further discussion with the aforementioned staff failed to confirm that the client had received a diet high in fiber, including raw fruits and vegetables and bran, as recommended in the ER discharge summary, dated 5/27/10. On 6/9/10 at 5:17 p.m., the review of the available menus revealed that they lacked a snack list and failed to include a meal pattern for a high fiber diet.	{W 460}		

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{R 000}	INITIAL COMMENTS A follow-up survey was conducted on 6/9/10 - 6/10/10, to verify that the facility had come into compliance with deficiencies identified in the licensure survey of 5/3/10. It should be noted that the current governing body was appointed by a court to manage this facility "in receivership," effective 5/14/10. The new management submitted a Plan of Correction dated 6/7/10. The follow-up visit revealed that there had been some progress made in the three weeks since the court action. However, through observation, interviews with staff and residents and review of records, the determination was made that the facility remained not in compliance with 22 DC Municipal Regulations, Chapter 47, Health Care Facility Unlicensed Personnel Criminal Background Checks, as evidenced in the report that follows.	{R 000}		
{R 125}	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the GHMRP failed to ensure criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 6 out of 13 direct support staff whose background check documentation was made available for review. (S1, S2, S3, S4, S7 and S8)	{R 125}	1 - 6. . An audit of all personnel files was conducted by MarJul Homes. The services of Global Investigation Services will be secured by July 14, 2010. This service will allow administrative staff to acquire a seven year, multi-state background check.	7/14/10

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 7-9-2010

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{R 125}	Continued From page 1 The findings include: On 6/9/10, at approximately 3:15 p.m., the facility's CEO indicated that 6 of the 13 direct support staff currently employed had been hired by the former provider agency management (prior to the 5/14/10 court hearing and receivership appointment). He further indicated that he thought criminal background checks for those 6 employees were "current." At approximately 3:45 p.m., he presented background checks and employment application forms for all 13 direct support staff employed. He stated that his agency routinely ensured that background checks covered all jurisdictions in which the applicant had worked or resided within the 7 years prior to the check. Beginning at 4:11 p.m., however, review of the personnel files revealed that the employment history for 8 of those staff not available. Additional information (i.e. employment histories) for some of those 8 staff was presented on the next day (6/10/10). Review of this information, beginning at 12:37 p.m., revealed the following: 1. The 6/9/10 review revealed that a background check had been performed for Staff #1 (hired by the former management) in Washington, DC on 2/18/10. Her employment history, however, was not available for verification. No additional information was presented before the survey ended at 3:45 p.m. on 6/10/10. 2. The 6/9/10 review revealed that a background check that covered Maryland, Washington, DC and Virginia had been performed for Staff #2 (hired by the former management) on 9/8/09. Her employment history, however, was not	{R 125}		

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{R 125}	Continued From page 2 available for verification. No additional information was presented before the survey ended at 3:45 p.m. on 6/10/10. 3. The 6/9/10 review revealed that a background check had been performed for Staff #3 in Washington, DC on 1/13/10. Review of her employment history on 6/10/10 revealed that she had worked in Silver Spring, Maryland from 10/04 - 8/05. Prior to 10/04 (but dates not specified), she had worked in Bladensburg, Maryland. There was no evidence of a background check that covered those jurisdictions. 4. The 6/9/10 review revealed that background checks had been performed for Staff #4 in Washington, DC and Maryland, on 7/2/09 and 2/2/10, respectively. However, review of her employment history on 6/10/10 revealed that she had worked in Falls Church, Virginia in 09, and had worked in Danville, Pennsylvania from 5/06 - 8/06. There was no evidence of a background check that covered those jurisdictions. 5. The 6/9/10 review revealed that a background check had been performed for Staff #7 in Washington, DC on 1/12/10. Review of his employment history on 6/10/10 revealed that he had worked in Baton Rouge, Louisiana from 1993 - 5/07. There was no evidence, however, of a background check that covered that jurisdiction. 6. The 6/9/10 review revealed that a background check had been performed for Staff #8 in Washington, DC on 3/31/09. Review of his employment history on 6/10/10 revealed that he had worked in Takoma Park, Maryland from 6/02 - 2005. There was no evidence however, of a background check that covered that jurisdiction.	{R 125}		

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{R 125}	Continued From page 3 This is a repeat deficiency. Previously, the deficiency report dated 5/3/10, included the following: Interview with the facility's House Manager on 4/29/10 at approximately 12:10 p.m. revealed the facility had hired four new staff since 12/09. Of the four newly hired staff, two of the criminal background checks failed to reflect a search was conducted in all areas where they either worked or lived over the past seven years as evidenced below: 1. Record review on 4/29/10, at approximately 12:20 p.m., revealed, Staff #2's job application listed him as either having worked or lived in the states of West Virginia and Pennsylvania within the past seven years. The criminal background check on record at the time of survey only covered the surrounding states of Maryland, Virginia and the District of Columbia. 2. Record review on 4/29/10, at approximately 12:25 p.m., revealed, Staff #3's job application listed him as either having worked or lived in the state of Florida within the past seven years. The criminal background check on record at the time of survey only covered the District of Columbia.	{R 125}		

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{I 000}	INITIAL COMMENTS A follow-up survey was conducted on 6/9/10 - 6/10/10, to verify that the facility had come into compliance with deficiencies identified in the licensure survey of 5/3/10. It should be noted that the current governing body was appointed by a court to manage this facility "in receivership," effective 5/14/10. The new management submitted a Plan of Correction dated 6/7/10. The follow-up visit revealed that there had been some progress made in the three weeks since the court action. However, through observation, interviews with staff and residents and review of records, the determination was made that the facility remained not in compliance with 22 DC Municipal Regulations, Chapter 35, Group Homes for Persons with Mental Retardation, as evidenced in the report that follows.	{I 000}		
{I 180}	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the group home for persons with mental retardation (GHMRP) failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for five of the five residents residing in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: 1. [Cross-refer to Federal Deficiency Report - Citation W153] The QMRP failed to ensure that	{I 180}	1. see W 153 2. see W 189.1 and W 252 3. see W 426 4. Nutrition training was conducted by a nutritionist and held on June 14th. See attached sign in sheet and curriculum. Nutritional assessments were completed and new menus were developed and placed in the home. 5. Nutrition training was conducted by a nutritionist and held on June 14th. See attached sign in sheet and curriculum. Nutritional assessments were completed and new menus were developed and placed in the home.	6/14/10

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{I 180}	Continued From page 1 staff received training on the facility's incident management policies, and abuse, neglect and resident rights. 2. [Crdss-refer to Federal Deficiency Report - Citations W189.1 and W252] The QMRP failed to ensure that direct support staff received training on consistent and accurate documentation of behavioral incidents. 3. [Cross-refer to Federal Deficiency Report - Citation W426] The QMRP failed to ensure that staff were trained on safe water temperatures (nct to exceed 110 degrees Fahrenheit). 4. [Cross-refer to Federal Deficiency Report - Citation W460.1] The QMRP failed to coordinate services to ensure menus were modified as necessary to provide Resident #3 high fiber foods, as prescribed. 5. [Cross-refer to Federal Deficiency Report-Citation W159.5] There was no evidence that the QMRP had followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3. Citation W460 in the Federal Deficiency Report dated 5/3/10, included the following: "According to the <nutritionist's 4/29/10> assessment, the resident was 'having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening.' At the time of the survey, however, the SLP screening had not been scheduled." On 6/9/10, at approximately 3:15 p.m., interview with the QMRP revealed that she had not	{I 180}		

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{I 180}	Continued From page 2 contacted the speech-language therapist (SLP) since she began serving as the QMRP on 5/14/10. She indicated that the facility's executive director planned to call the SLP to schedule appointments. She further indicated that the SLP "has to come. We're going to get everyone an assessment...all of them are outdated." On 6/9/10 at approximately 5:10 p.m., a direct support staff was observed in the kitchen, chopping food with a knife. When asked, she stated that she and other staff always chopped Resident #3's foods to help his swallowing. However, review of the resident's physician's orders failed to show evidence that the recently-assigned PCP had been made aware of the previous recommendations for altered food texture and an SLP screening. On 5/19/10, the PCP wrote the following dietary orders: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily." [It should be noted that on 6/2/10, a new nutritionist wrote "<Resident #3> was assessed for a complete nutrition evaluation...The current diet of mechanical soft texture is synonymous to a ground diet ... <Resident #3> should receive a ground texture."] This is a repeat deficiency. --- Previously, the federal deficiency report dated 5/3/10, included the following: 1. The facility's QMRP failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective for Residents #3 and #4. [See W252]	{I 180}		

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{I 180}	Continued From page 3 2. The facility's QMRP failed to coordinate services to ensure menus were modified as necessary to provide the prescribed diet of Resident #3. [See W460]	{I 180}		
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the group home for persons with mental retardation (GHMRP) failed to ensure staff was effectively trained on documenting targeted maladaptive behaviors in the residents' behavior data; incident management and recognizing potential abuse; maintaining safe water temperatures; and, ensuring that Client #3 received high-fiber snacks as prescribed, for 13 of the 13 direct support staff in the facility. The findings include: 1. [Cross-refer to Federal Deficiency Report - Citation W252] On 6/9/10, at approximately 8:15 a.m., Resident #3 was observed to remove all of his clothing while standing in the living room. Review of his records the next day, at 8:55 a.m., revealed that the staff who were on duty at the time failed to document the incident in on his behavior data sheets. Another behavioral incident was indicated in a staff log entry on 6/6/10; however, it too had not been documented in the program book, in accordance with the resident's behavior support plan (BSP), dated 4/19/10. On 6/9/10, at approximately 3:15 p.m., interview	I 222	1. See attached Training Schedule 2. All staff have been trained on the implementation of the incident management system and reporting policies. see attached training schedule) 3. All staff have been trained on safe water temperature practices. (see attached staff memo and training schedule) 4. Nutrition training was conducted by a nutritionist and held on June 14th. See attached sign in sheet and curriculum. Nutritional assessments were completed and new menus were developed and placed in the home.	6/22/10 And 6/25/10 7/9/10 6/14/10

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I 222	Continued From page 4 with the qualified mental retardation professional (QMRP) revealed that the facility had not provided in-service training since new management was appointed by a court on 5/14/10. This was corroborated a short time later (4:05 p.m.) by two direct support staff who were interviewed. 2. [Cross-refer to Federal Deficiency Report - W153] The facility failed to ensure staff was trained on recognizing abuse and neglect, resident rights and the facility's incident management policies. On 6/9/10, at 11:58 a.m., review of Resident #4's behavior data and Daily Progress Notes revealed that staff had documented an incident 5/25/10 when Resident #4 hit Resident #3 on the head. On 6/9/10, at approximately 12:30 p.m., the qualified mental retardation professional (QMRP) stated there had been no reports of anyone being hit in the head or face since she was assigned as QMRP on 5/14/10. If staff were to witness a resident hit another resident, "that would be abuse." On 6/9/10, at approximately 3:15 p.m., the QMRP acknowledged that they had not provided in-service training for staff on their incident management system since 5/14/10. At 4:05 p.m., interview with two direct support staff confirmed that there had been no training on incident management or abuse/neglect. On 6/10/10, at 2:50 p.m., the QMRP indicated that staff training had not yet been scheduled for abuse and neglect, resident rights and incident management policies. She added, however, that "it will be" scheduled soon. 3. [Cross-refer to Federal Deficiency Report - W426] The morning shift had documented hot	I 222		

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I 222	Continued From page 5 water temperatures exceeding 110 degrees on three different dates (6/1/10, 6/5/10 and 6/9/10) and failed to notify management, as per written instructions. On 6/9/10, at approximately 3:15 p.m., the QMRP acknowledged that they had not provided in-service training for staff on maintaining safe water temperatures. At 4:05 p.m., interview with two direct support staff confirmed that there had been no training provided. On 6/10/10, at 2:50 p.m., the QMRP indicated that staff training on nutrition (6/14/10) was the only topic scheduled thus far. 4. [Cross-refer to Federal Deficiency Report - Citation W460] On 6/9/10, at 4:16 p.m., Resident #3 was offered sugar wafers for afternoon snack. The nutritionist, however, had recommended that he receive hi-fiber snack items, in part to address recurrent bouts of constipation and fecal impactions. Interview with the direct support staff on 6/9/10, at approximately 5:10 p.m., revealed that she was previously unaware of the recommended hi-fiber snacks. She stated that she had not received any training on diet plans and snack choices. She further indicated that there was no list of hi-fiber snacks available for staff reference. On 6/9/10, beginning at 3:11 p.m., the qualified mental retardation professional (QMRP) stated that the facility had not provided staff in-service training since the new management team was appointed on 5/14/10. This was also verified through review of training records on 6/10/10, at approximately 1:00 p.m. [Note: On 6/10/10, at 2:50 p.m., the QMRP pointed to announcements posted in the facility, for mandatory staff training by the nutritionist. It was scheduled for 6/14/10.]	I 222		

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{I 227}	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review and staff interview, the group home for persons with mental retardation (GHMRP) failed to ensure all staff completed training in performing first aid and cardiopulmonary resuscitation (CPR), for 4 of 9 staff whose training status was reviewed. (Staff S1, S2, S4 and S7) The finding includes: On 6/10/10, beginning at 12:37 p.m., review of personnel record revealed no evidence that staff S1, S2, S4 and S7 had current CPR certification and First Aid training. It should be noted that S1 and S2 had been employed by the former residence manager, while S4 and S7 had been employed by the new management, prior to their receivership appointment by a court on 5/14/10. The CEO/administrator acknowledged that some staffs' certifications had expired. He further indicated, however, that the next training had been scheduled for July 2010. This is a repeat deficiency. --- Previously, the licensure deficiency report dated 5/3/10, included the following:	{I 227}	See Training Calendar	

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{I 227}	Continued From page 7 Interview with the facility ' s House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/09. Record review on the same day at approximately 12:55 p.m. revealed, none of the four staff records reviewed showed evidence of either first aid or CPR training. The GHMRP failed to ensure all staff received training in the areas of implementing First Aid or CPR as required by this section.	{I 227}		
{I 379}	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview, review of resident behavior data and review of incident reports and investigations, the group home for persons with mental retardation (GHMRP) failed to notify the Department of Health, Health Regulation and Licensing Administration (HRLA) of an incident where one resident assaulted another resident, for one of the five residents in the GHMRP. (Resident #3)	{I 379}	All staff have been trained on the implementation of the incident management system and reporting policies. (see attached training schedule) (see attached sign in sheet)	6/22/10 And 6/25/10

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(I 379)	Continued From page 8 The finding includes: On 6/9/10, at 11:58 a.m., review of Resident #4's behavior Antecedent Behavior Consequence (ABC) data sheets revealed that on 5/25/10, at 4:30 p.m., a direct support staff person wrote: A - "She was sitting down talk about food and going to the store. " B - "She hit <Resident #3> in the head and lip." C - "Tell her to stop and happy face and smiley face and she stop <sic>. She said she's sorry to <Resident #3>." Review of Resident #4's Daily Progress Notes revealed that the same staff had documented "yes" the resident had "displayed behaviors" and "no" there were no incidents. There was no corresponding incident report in the facility. A pre-survey review of incident reports had not revealed any incidents of physical abuse. On 6/9/10, the qualified mental retardation professional (QMRP) arrived in the facility at approximately 12:30 p.m. She stated there had been no reports of anyone being hit in the head or face since she was assigned as QMRP on 5/14/10. If staff were to witness a resident hit another resident, "that would be abuse." She further stated that the facility's policies require staff to notify their supervisor and the QMRP would instruct them to complete an incident report. On 6/9/10, beginning at 4:46 p.m., review of the facility's Incident Management System (IMS) Policy and Procedures (not dated) confirmed what the QMRP had stated earlier. The IMS was "designed to protect individuals from harm ... ensure timely and accurate notification of appropriate staff, families and agency officials ... ensure completion of investigation and	(I 379)		

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{I 379}	Continued From page 9 documentation of incidents ... corrective action to prevent the recurrence of similar incidents ... staff training in the prevention, detection, reporting and investigation of incidents." Abuse of an individual by another individual was prohibited and "physical abuse" was defined to include "intentionally or willfully grabbing ...slapping, hitting ...punching, or otherwise wrongfully handling an individual." On 6/9/10, beginning at 2:16 p.m., review of the Daily Log Book (In which staff documented their activities throughout their shift), revealed the following entry dated 5/25/10, 4:30 p.m.: "<Resident #4> hit <Resident #3>. She went into her behavior then <Resident #3> went into he's <sic> behavior but <Resident #4> are all right, and she busted <Resident #3> mouth open, yes he's ok." On 6/9/10, at 3:55 p.m., the direct support staff whose initials were on the Daily Log Book entry replied "no" when asked if any resident had been hit by a peer. The same staff was interviewed again the next day at 3:47 p.m., at which time he confirmed Resident #4 had hit Resident #3 in the head. He further described that after he was hit in the head, Resident #3 started biting his own hand, fell to the floor crying and continued acting out. There was no evidence that HRLA was notified of the 5/25/10 incident. The staff had not completed an incident report, in accordance with their policy. It should be noted that the current governing body was appointed by a court to manage this facility, effective 5/14/10. On 6/9/10, at approximately 1:40 p.m., interview with the QMRP revealed that six of their thirteen direct support staff had been employed by the previous provider agency. At approximately 3:15 p.m., she acknowledged that they had not provided in-service training for staff	{I 379}		

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{I 379}	Continued From page 10 on their incident management system since 5/14/10. At 4:05 p.m., interview with two direct support staff confirmed that there had been no training on incident management or abuse/neglect. This is a repeat deficiency. --- Previously, the licensure deficiency report dated 5/3/10, included the following: Review of the GHMRP's incident reports and corresponding investigative reports on 4/30/10, beginning at 6:52 p.m., revealed no evidence that HRLA received timely notification of the following four incidents: 1. An incident report (injury of unknown origin) dated 2/8/10, revealed that Resident #1 complained to staff that his neck was bothering him. The resident was taken to an emergency room for evaluation and treatment. 2. An incident report dated 11/8/09, and corresponding investigation report dated 11/10/09, revealed an allegation of sexual abuse. Resident #1 reported to staff that another staff had put his hands down his pants. 3. An incident report dated 9/26/09, and corresponding investigation report, revealed an allegation of verbal/physical abuse. Resident #2 came into the QMRP's office and stated that a counselor told him to "shut up" and pushed him off the van. 4. An incident report dated 10/2/09, and	{I 379}		

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{I 379}	Continued From page 11 corresponding investigation report dated 10/13/09, revealed an allegation of verbal abuse. While in court, Resident #2 kept raising his hand to speak. The judge allowed him to speak, and the resident stated "staff was hollering at" him.	{I 379}		
{I 401}	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with mental retardation (GHMRP) failed to ensure professional services included timely diagnostic, evaluation, and treatment services to prevent deterioration or further loss of functioning, for two of the four sampled residents. (Residents #3 and #4) The findings include: I. Based on observation, interview, and record review, the facility failed to ensure timely preventive health services, for Residents #3 and #4, as follows: A. The monitoring survey conducted from 4/29/10 to 5/3/10 revealed Resident #3 had a history of bowel obstruction and multiple emergency room (ER) visits due to constipation. During the monitoring survey, on 4/30/10, Resident #3 was taken to an ER after complaining of abdominal pain. Review of the resident's bowel movement	{I 401}		

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{I 401}	Continued From page 12 (BM) records on 4/30/10 revealed that his most recent BM had been documented on 4/24/10, 6 days earlier. His physician's orders included two different medications (constulose or milk of magnesia MOM) to be administered PRN for constipation. The orders, however, did not specify when to administer one or the other medication. There were no other instructions or protocol available to further clarify. On 5/3/10, at 7:40 p.m., the Supervisory Registered Nurse (RN) confirmed that Resident #3's record failed to include instructions or a protocol on when he was to receive the PRN medications. This deficient practice was cited in the federal deficiency report dated 5/3/10. The follow-up survey initiated on 6/9/10, revealed that the facility still had not established a written protocol or obtained orders that clarified when to administer Resident #3's PRN medication for constipation, as follows: On 6/9/10, beginning at approximately 8:50 a.m., the licensed practical nurse coordinator (LPNC) described how on 5/27/10, a medication nurse had observed Resident # 3 lying on the floor and complaining of stomach pains. The nurse telephoned 911 and the resident was transported to the ER for evaluation. The ER discharge summary revealed a primary diagnosis of stomach pain and a secondary diagnosis of constipation - acute abdominal: fecal impaction. At approximately 8:57 a.m., the LPNC stated that although there were no written instructions or orders on administering the PRN lactulose or MOM, she was expected to administer the PRN as a laxative if Resident #3 did not have a BM in 3 days. Further review of the hospital discharge summary	{I 401}	I. A. The administration at MarJul Homes recognizes the importance of safe medication practices and medical follow up. A policy regarding the safe use of PRN medications has been developed. All nursing staff have been trained on this policy. In addition, all staff have received training on the protocol for Bowel Movement documentation and monitoring. (see attached sign in sheet) B. We recognize the importance of timely follow up on laboratory results and communications with the physicians. All nurses have been trained on laboratory/ diagnostic testing protocol. II. We recognize the importance of dental care and all dental appointments, both preventative and acute, have been scheduled. We will ensure that the periodontal care is continued regardless of payment method. III. All individuals have been scheduled for an evaluation with an SLP. The nutritionist performed an evaluation and provided staff training on the newly prescribed diet orders/food textures. (see attached nutrition reports)	And 6/25/10

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{I 401}	Continued From page 13 revealed the following recommendations: provide Resident #3 a diet high in fiber, including raw fruits and vegetables and bran to prevent constipation; 10 to 12 cups of water daily; Dulcolax 5 every evening for 10 days; and, contact your primary care physician (PCP) as soon as possible to schedule a follow-up appointment in 2-3 days. On 6/9/10, at approximately 11:50 a.m., review of Resident #3's nursing progress note revealed an entry dated 5/27/10, (5:10 p.m.) which documented that the PCP was notified of the outcome of the ER visit and the discharge recommendations. The PCP concurred with the hospital recommendation to begin administering Dulcolax 5 mg tab, 1 tab daily. The 5/28/10 physician's orders continued to include Enulose and Milk of Magnesia as PRN medications. The orders did not, however, specify when to administer either one or the other medication PRN for constipation, nor did the orders address daily water/fluid intake. On 6/9/10, at approximately 2:45 p.m., review of Resident #3's bowel movement (BM) records revealed that staff documented a BM on 5/27/10 during the evening shift. The next documented BM was during the evening shift on 6/1/10, 5 days later. Review of the MAR revealed that the LPNC administered MOM at 3:00 p.m. on 6/1/10 again on 6/2/10. It should be noted that the corresponding nurse progress note from 6/1/10 indicated that the resident had been 3 days without a BM, whereas his BM chart showed 5 days. After she administered the MOM on 6/1/10 and 6/2/10, the nurse documented a call to the PCP on 6/3/10, at which time the PCP increased the	{I 401}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0202	A. BUILDING _____ B. WING _____	R 06/10/2010

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{I 401}	Continued From page 14 Dulcolax from 5 mg daily to 10 mg every evening. On 6/10/10, at 3:00 p.m., the resident's BM chart showed that his stools remained mostly hard between 6/4/10 - 6/8/10. When the resident went to the PCP's office on 6/10/10 for a "post-ER visit," she discontinued the PRN Lactulose order and started him on Lactulose 30 ml every evening. However, as of 6/10/10, Resident #3's record failed to include instructions or a protocol on when he was to receive "Milk of Magnesia 30 ml by mouth every evening as needed for constipation." B. The facility's medical team failed to establish and implement a system to ensure timely review of the findings/reports of diagnostic laboratory tests. [Cross-refer to Federal Deficiency Report - Citation W331.2] Residents #3 and #4 had both received lab testing on 5/20/10 as ordered by the PCP. The results were reported to the facility by facsimile on 5/25/10. However, further review of the residents' medical charts followed by interviews with the qualified mental retardation professional and the LPNC (on 6/9/10, at 1:16 p.m. and 6/10/10, at 9:50 a.m., respectively) revealed that to date, the lab report findings had not been shared with or reviewed by the PCP. [Note: Resident #4's urinalysis showed abnormal results and Resident #3's report indicated elevated serum potassium.] II. Based on interview and record review, the facility failed to ensure timely dental services for Resident #3, as follows: The monitoring survey conducted from 4/29/10 to	{I 401}		

Health Regulation Administration

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{I 401}	Continued From page 15 5/3/10 revealed on 10/1/09, the periodontist diagnosed Resident #3 with severe gingivitis, heavy plaque and calculus, and generalized caries of teeth #4, #12 and #15. During a dental visit on 2/3/10, and again on 4/7/10, the periodontist recommended that the resident's "Generalized caries" needed to "be addressed by general dentist." These findings were previously cited in the federal deficiency report dated 5/3/10. Interview with the licensed practical nurse coordinator (LPNC) on 6/10/10, at 3:35 p.m., revealed Resident #3's caries of teeth #4, #12 and #15 had not been addressed, to date. Continued interview with the LPNC, however, revealed a 6/9/10 previously scheduled appointment with the periodontist had been kept; however, no services were rendered. On 6/10/10, at 3:42 p.m., review of the dental consultation report dated 6/9/10 revealed that Resident #3 was denied treatment services because the periodontist did not participate in the Medicaid program. At the time of the 6/10/10 survey, there was no evidence that the Resident #3's caries had been filled as recommended by the periodontist on 10/1/09. III. Based on observation, interview and record review, the facility failed to address the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3, as follows: Citation W460 in the Federal Deficiency Report dated 5/3/10, included the following: "According to the <nutritionist's 4/29/10> assessment, the resident was 'having difficulty swallowing regular	{I 401}		

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{I 401}	Continued From page 16 consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening.' At the time of the survey, however, the SLP screening had not been scheduled." On 6/9/10, at approximately 3:15 p.m., interview with the QMRP revealed that she had not contacted the speech-language therapist (SLP) since she began serving as the QMRP on 5/14/10. She indicated that the facility's executive director planned to call the SLP to schedule appointments. She further indicated that the SLP "has to come. We're going to get everyone an assessment...all of them are outdated." On 6/9/10 at approximately 5:10 p.m., a direct support staff was observed in the kitchen, chopping food with a knife. When asked, she stated that she and other staff always chopped Resident #3's foods to help his swallowing. However, review of the resident's physician's orders failed to show evidence that the recently-assigned PCP had been made aware of the previous recommendations for altered food texture and an SLP screening. On 5/19/10, the PCP wrote the following dietary orders: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily." [It should be noted that on 6/2/10, a new nutritionist wrote "<Resident #3> was assessed for a complete nutrition evaluation...The current diet of mechanical soft texture is synonymous to a ground diet ... <Resident #3> should receive a ground texture."]	{I 401}		